NEW YORK CITY BOARD OF CORRECTION

REPORT ON PRISON SUICIDES AND URGENT RECOMMENDATIONS FOR ACTION

August 12, 1972

The number of suicides and attempted suicides in the City correctional institutions continues at an alarming rate. There were 11 prison suicides in 1971. Despite the public attention given to those suicides, and despite many positive changes, 1972 has already witnessed nine suicides. (See Table I.) In the first month of this summer, from June 16th to July 14th, there have been three suicides and countless attempted suicides. (Correctional personnel estimate that for every suicide there are at least 25 attempted suicides.)

The Board of Correction believes that any system of incarceration is unacceptable which fails to take every reasonable step to avoid self-destruction or suicidal behavior by those who are committed to its custody. The Board believes that the prison system, which should be designed to avoid self-destruction, frequently is the cause of it because of the oppressive, dehumanized environment where mentally disturbed prisoners are housed.

On November 17, 1970, the Board of Correction issued an investigative report concerning the death of Julio Roldan, an inmate in the Manhattan House of Detention for Men (The Tombs).

We presented a number of recommendations with the report, including the following, which were directed to suicide prevention:

> -- Urgent priority should be given to the establishment of psychiatric and medical wards, including plans for more dormitory-style prison facilities.
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> -- Those charged with delivering prisoners from the courts to an institution should report any observation of disturbing prisoner behavior so that the receiving officers can make appropriate classification assignments.
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> -- A program of orientation for prisoners should be organized so that prison discipline and expectations can be communicated and prisoners can have an opportunity to ask questions regarding their care.
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> -- More Spanish-speaking personnel must be employed at all levels of the Department.

The report stated: "Julio Roldan died by his own hand on October 16, 1970, but the intricate system of criminal justice which we have designed to protect the community and the individual succeeded only in deranging him and ultimately, instead of protecting him, it permitted his destruction." Nearly two years have passed since Roldan's death, yet this same statement can still be made as each new inmate suicide is added to the tragic list.

Three months after the Roldan report, on February 18, 1971, the Board of Correction publicly listed 51 recommendations

related to the reform and improvement of prison conditions. A number of these recommendations related directly to the problem of inmate suicides. For example:

Recommendation #6: Clerks of the court should be obligated to report unusual or disturbed behavior of prisoners in a courtroom.

This is now the officially promulgated practice in all courts throughout the City. Neither the Department of Correction nor the clerks of the courts, however, can report figures to indicate the frequency with which such reports are made. Nor can the Department of Correction provide, except for a broad, general statement, any sense of what its response has been in cases where unusual courtroom behavior has been so noted.

Recommendation #16: The City . . . must relax the "freeze" on municipal employees by the appointment of new personnel to meet critical needs.

The Board of Correction reported, in its letter to Mayor Lindsay of June 17, 1971, that the freeze had been "relaxed somewhat in the hiring of medical and psychiatric personnel for the Department." The problem, however, is not alone in numbers. The motivation, personal commitment, and experience of medical

personnel are critical factors in their attitude toward the treatment of prisoners. Important progress is observable, but the Board remains concerned, however, about the availability and quality of medical assistance.

A striking example of the inadequate medical treatment available to mentally disturbed inmates was the February 19, 1971 suicide of Robert Cruz, an inmate at the Adolescent Remand Shelter. In the words of Warden Thomas' report on Cruz's death: "Subsequent investigation revealed that the medication ordered by Dr. Rooney was never given to inmate Cruz . . . The possibility exists that if Cruz had received the sedatives prescribed by the doctor at the time of his admission, it might have deterred his suicide." As the result of a sexual assault on a Friday evening, Cruz had been told to see the psychiatrist, but he was only available on Mondays. The weekend was too long to wait; Cruz committed suicide on Saturday.

Recommendation #35: There must be more Spanish-speaking personnel.

Of the nine suicides thus far this year, six were committed by inmates of Hispanic background. The communication obstacles and the confusion facing Spanish-speaking inmates were again illustrated by the suicide of Demetrio Perez. While clearly in a distressed state, Mr. Perez was given thorazine by

one institutional physician the night before his suicide, instructed to be remedicated on the morning of his suicide, and instead given two aspirin tablets by a different physician. The absence of Spanish-speaking personnel seems to have been a major obstacle to effective assistance. An inmate with psychological problems desperately needs someone to whom he can immediately communicate his urgent feelings. The shortage of Spanish-speaking correction officers and medical personnel means that Hispanic inmates in this condition must often convey their feelings through an intermediary, if at all. The added toll on such inmates, in their state of mental anxiety, may be a critical factor in their attempts at suicide.

In February, 1972, the Board made five specific recommendations to assist Hispanic prisoners in adjusting to prison life, to help their reintegration into the community, and to begin the process of rehabilitation:

1. Programs to teach English as a second language to Spanish-speaking inmates;

2. A well-organized literacy program, accompanied by the addition of more books in Spanish to prison libraries;

3. Employment of bilingual detainees as

interpreters for Spanish-speaking inmates: one inmate, to be available around the clock, should be designated in each housing area to communicate with non-English-speaking inmates;

4. An expanded program, coordinated by the Department of Correction and in cooperation with Hispanic community groups, to provide Hispanic cultural events in the prisons;

5. Intensified recruitment of Spanish-speaking personnel at all levels of the Department, including programs for the training of Spanish-speaking correction officers.

Recommendation #40: Examination and individual care of medical complaints must be the operative policy of the prisons.

After the Board's public hearings into the problems of prison suicides last August, the Health Services Administration was given the responsibility for medical care in Correctional facilities. Working with the Department of Correction, HSA has made significant and commendable progress in meeting the objective of individual medical care. Much remains to be done.

Recommendation #41: Psychiatric hospital facilities for prisoners should be made available in the Bronx.

We reported on June 17, 1971 that the Department of Correction, the Health Services Administration, and officials of Van Etten Hospital were planning to establish a psychiatric hospital facility at Van Etten in the Bronx. In addition, the Department, HSA and the Department of Public Works were to be working on the modification of the sixth floor of the Rikers Island Infirmary into a psychiatric facility with a larger capacity than the present Bellevue ward. Plans called for completion of construction, staffing and supplying by July, 1971. The goal for the Rikers Island Infirmary was met. At present there are 50 inmates in the sixth floor "Mental Health Therapeutic Community." The average stay there is 90 days; the maximum is six months.

The "suicidal" inmate, however, is generally not confined to the sixth floor mental therapeutic area. According to the senior psychologist at the Rikers Island Infirmary, the lengthy procedure through which disturbed inmates are channelled to the sixth floor of the Infirmary generally excludes "high risk" inmates. The most disturbed and suicide-prone inmates are usually confined to the "mental observation" cells of the Infirmary's second and third floors. Three inmates have committed suicide this year while confined in these cells.

In the other prisons, inmates with psychological problems

BLE I. INMATE SUICIDES IN N.Y.C. PRISONS AS OF AUGUST 1, 1972

o.	Date	Inmate's Name	Age	Ethnic Background	Institution	Length of Incarceration	Relevant Information
1.	3-13	Kilgannon, Wm.	29	White	Manhattan HD	7 days	Drug addict; prior psychiatric history and suicide attempts.
2.	3-29	Sulas, Wilifredo	23	Hispanic	Rikers Is. Hospital	7 days	Psychiatric record.
3.	5-7	Muniz, Herbert	30	Hispanic	Rikers Is. Hospital	7 days	Drug-related offense; prior psychiatric history.
4.	5-27	Perez, Demetrico	44	Hispanic	Adult Remand Shelter	3 months, 13 days	In "mental observation" area; awaiting sentence.
5.	6-6	Enge, Gary	25	White	Brooklyn HD	27 days	Drug addict; prior psychiatric history.
6.	6-16	McCollum, Larry	25	Black	Manhattan HD	14 days	Held for psychiatric clinic.
7.	7-10	Acosta, Eliseo	36	Hispanic	Adult Remand Shelter	20 days	Drug addict; died at Elmhurst Hospital four days after hanging (7-14).
8.	7-11	Vargas, Pablo	18	Hispanic	Rikers Is. Hospital	1 month, 17 days	Drug addict; previous suicide attempts.
9.	7-31	Olivares, Louis	33	Hispanic	Brooklyn HD	5 months, 15 days	Drug addict.

TABLE I

are shuttled off to "administrative segregation" or "mental observation" areas, which are in truth no more than cages. There is no physical difference between a "mental observation" cell, an "administrative segregation" cell, and a "punitive segregation" cell. Inmates generally regard each with equal anguish and frustration.

The record of the Bellevue Hospital prison psychiatric ward demonstrates that suicides can be prevented. Nurses' aides, who are trained in suicide detection and prevention, are on standard, constant patient-watch in the prison wards. Meetings among the aides are held each morning, at which time each case is discussed and recent behavioral symptoms are reviewed and analyzed. Inmate patients are treated in dormitory facilities or in individual rooms specially designed to offer little or no opportunity for self-harm, for rare cases of unusually violent inmates. Even then, these inmates are kept in such rooms only during nighttime hours. Constant personal contact between the nurses' aide and the patient is emphasized.

There have been no suicides within memory at the Bellevue prison ward. Captain Yarmolinsky, who has been assigned to the prison ward for the last 14 years, estimates that there have been five suicide attempts within the last two years, by

either wrist-slashing or attempted hanging. An inmate who is discovered with torn strips of sheets is considered an attempted suicide by the hospital.

Recommendation #49: Sensitivity training should be a regular part of the training of Department of Correction personnel, certainly for those who have direct and frequent contact with prisoners.

The Urban League currently operates most aspects of correction officer training at the Correctional Academy. As part of their training program, correction officers receive lectures on suicide prevention from Mr. Wicks, Counsellor, Addiction Treatment Services.

This program as presently operated, however, is an inadequate solution to the problem of correction officers' dealings with suicidal inmates. There must be permanently-assigned and specialized suicide-oriented correction officers manning every mental observation area in an institution. The present practice of shifting correction officers constantly from one assignment to another results in haphazard attention to the critical needs of disturbed inmates.

In addition, as Dr. Edward Kaufman, Director of Psychiatry for the Department of Correction, has suggested, each

correction officer should be given continuing on-the-job instruction in the detection and proper treatment of potential suicides.

These recommendations are repeated here to demonstrate that many of the fundamental problems at the root of inmate anxieties have long been recognized. Yet, as this year's suicide toll indicates, the response has not met the need.

The Board of Correction, therefore, calls upon the City government to commit itself to the following action:

1. The priority construction of a central psychiatric treatment area on Rikers Island for all disturbed inmates.

2. Inmates with suicidal tendencies, suffering from mental anxiety or depression, will no longer be confined in cells unless such cells are designed to meet the special safety and security needs of such prisoners.

3. As an emergency measure, until Recommendation 1 is fully implemented, the present "mental observation" areas at the Rikers Island Infirmary must be reconstructed to remove the cages, with round-the-clock psychiatric attention and observation, and specially-padded rooms, for those few inmates who pose a threat to others.

The Board was assured, following Perez' May 27th suicide, that there would thereafter be round-the-clock psychiatrists at Rikers Island. At present, there is seven-day psychiatric coverage, an improvement over the absence of psychiatrists on weekends, but round-the-clock coverage is still lacking. The present practice of isolating mentally disturbed inmates in "administrative segregation" or "mental observation" cells is not conducive to the benefits of psychiatric treatment. The likelihood of more inmate suicides necessitates immediate action to transform the cages presently holding mentally disturbed inmates into decent facilities for observation and care. A cell with protruding fixtures, bunks, barred windows and cell-front grillwork presents a ready opportunity to an inmate bent on suicide by hanging. Visual observation of inmates confined to such cells is minimal; they can never be made suicide-proof except with constant observation, literally round-the-clock.

Within these dormitory areas which we recommend, inmates diagnosed as high suicide risks should be under constant 24-hour observation by trained personnel. Unnecessary isolation should be eliminated.

Clothing, such as belts and shoelaces, and other

materials should be removed. Throw-away hospital robes might be appropriate garb. In addition, disposable towels and sheets should be used. The newly-constructed dormitory areas should be devoid of grillwork, railed beds, double bunks, and fixtures, apertures, and protrusions from which someone can hang himself.

Therefore, construction work should begin immediately on the second and third floors of the Rikers Island Infirmary. Partitions separating each of the 15 cells per tier should be removed, thus creating an enlarged observation area.

At present, inmates who are high suicide risks should immediately be transferred to the medical wards of the fourth and fifth floors and placed under constant 24-hour watch. We can no longer tolerate the placement of suicidal inmates in danger-ridden cells, subject only to observation by touring suicide-prevention aides at 15-minute intervals. Every feasible precaution to save human life must be taken at once.

4. The present "suicide-prevention aide" program should be evaluated.

A cursory reading of the Department's Unusual Occurrence Reports demonstrates that many lives have been saved since the inception of the program in April of this year. The role of the correction officer in this daily business of life-saving is nothing short of heroic. There is, however, no

indication that the suicide-prevention aide program has been analyzed in depth to determine its effectiveness or any possible patterns which may have emerged from recorded suicides or attempts.

The Board of Correction has received varied indications of the effectiveness of this program. The suicide-prevention aides are all inmates. Some of them are genuinely conscientious, with some prior hospital experience, and they participate in regular training sessions with psychiatrists in the institution. Others seemed to have been "requested" to serve as suicide-prevention aides, lacking either the training or the will to serve disturbed inmates.

5. The operation of all mental health programs affecting inmates should be evaluated.

There must be a serious effort to learn from various mental health programs now in operation and to improve each. The fact that the Bellevue Hospital prison psychiatric ward has a suicide-free record should point to it as a model for the treatment of disturbed inmates. What has been done on a Departmental level to share the methods of Bellevue with Kings County, Elmhurst or, even more crucially, the Rikers Island Infirmary?

Furthermore, communication and cooperation between psychiatrists on duty in hospital prison wards and institutional medical personnel must be improved. The Board of Correction learned from Prison Mortality Review Board hearings that the relationship of correctional personnel to outside hospital doctors is sometimes strained. There are complaints of proliferation of mental health workers in some areas and their absence in others. At a time when productivity of public employees is a principal concern, we believe a thorough study and evaluation of the mental health program is appropriate.

Often, inmates diagnosed by the correctional staff as needing psychiatric attention are routinely returned to the particular institution after being seen by hospital staff psychiatrists. Outside doctors demonstrate little respect for diagnoses made by prison medical staffs. An inmate who is behaving in a clearly psychotic manner while at the institution is often diagnosed as not psychotic or disturbed by the time he is seen by an outside hospital psychiatrist. The hospital psychiatrist generally sees an inmate in a calm state, since he is usually likely to be much calmer once he is away from the prison atmosphere, even for only a few minutes. On the basis of this inadequate examination, hospital psychiatrists

regularly conclude that the inmate is merely a "behavioral problem", ignore the diagnosis of the correctional staff, and send the inmate back to the institution. This usually happens within the space of a few hours. The burden which this practice places on the institution and on the correction officers who must deal with the inmate is onerous and unnecessary.

6. There must be a rational, professional classification of inmates to facilitate their placement and treatment.

The St. Louis City and County jail systems have not had a suicide since 1968. There is a professional classification system in operation. When the inmate first arrives, he is isolated until he is classified. The classifiers are individuals with correctional experience as parole and probation officers, who have graduate school training. They review the available information on the inmate: previous reports from the police, correctional and medical records. They then interview and test the inmate. If the inmate is felt to be a suicide risk, he is classified as such and placed in a special cell area where he is observed round-the-clock, either by an assigned correction officer or an inmate volunteer.

A maximum effort should be made at all stages from initial arrest to transfer of custody to identify disturbed

inmates and transmit vital information to all institutional personnel who come into contact with such inmates. Then, the information so transmitted must be translated into acceptable levels of care and supervision.

The lack of such a procedure has been brutally evident in a number of suicides this year. For example, Gary Enge, a Brooklyn House of Detention inmate who hanged himself on May 25th, had a long history of mental illness: confinement to Mattawan State Hospital in 1963 and 1968 and a stay in Brooklyn State Hospital in 1971. He had attempted suicide by slashing his wrists in 1971; this fact had been communicated to a doctor at the Brooklyn House of Detention and noted on Enge's medical record. Yet Enge killed himself while in a double cell on the medication floor, to which he had been transferred only because of his complaint of a skin allergy. There was no special facility on that floor to supervise or observe disturbed inmates.

Upon admission, a thorough physical exam is necessary in order that a detailed record of an inmate's medical problems be maintained. Notations of all medication administered to an inmate must be kept accurately and consulted by all medical personnel who treat the inmate. This will assist in curbing

over- or under-medication.

There must be a screening procedure in which an inmate is interviewed by a psychiatrist or psychologist or social worker or other trained personnel. This procedure should be particularly intensive where a history of mental disorder is indicated. The results of this procedure should be decisive in determining the placement of the individual in a psychiatric ward, or a cell with a partner, or a solitary cell.

A follow-up system for all recognized mentally disturbed cases must be established. All unusual developments in inmate behavior must be reported to a physician or psychiatrist, who will thus be better informed to evaluate suicidal tendencies.

A record of an inmate's medical problems should be posted outside his cell or dormitory area, indicating all medicine prescribed and all mental or physical disorders. If an inmate is a high suicide risk, this must be conspicuously noted. A form should be designed to highlight the most important information.

It should be noted that there is a screening procedure operating at the Adolescent Remand Shelter on Rikers Island. A specially designed questionnaire is administered to every inmate upon his admission by a team of mental health workers and patient aides, under the training and supervision of a psychologist at

the Adolescent Remand Shelter Mental Health Unit. The procedure is designed to screen out inmates in more seriously depressed conditions, who are most likely to attempt suicide. The screening procedure has been in operation for four months; there have been no suicides at the Adolescent Remand Shelter this year.

The Women's Correctional Facility on Rikers Island has a less extensive screening procedure; no other City correctional institution has such a procedure at present. This procedure should be expanded to every correctional institution in this City. Correction officers should be included in the screening team that administers the questionnaire and evaluates each incoming inmate.

7. There should be two or more courtrooms opened at Rikers Island.

Disturbed inmates are often shuffled back and forth to court in hot vans for considerable distances. The presence of court facilities on the Island, established for the handling of mentally disturbed inmates' cases, would alleviate the ordeal of repeated trips to court. The Kings County Supreme Court has established a Special Term, Part 7, whereby judges visit the psychiatric ward of Kings County Hospital weekly, to review the

cases of inmates receiving psychiatric examinations and treatment. The Bellevue Hospital Prison Ward also has a seventh floor courtroom for weekly judicial sessions. An extension of this practice at Rikers Island could easily relieve one source of psychological strain on distrubed inmates.

8. Correction officers should be specially trained and permanently assigned to mental observation areas, where they can deal personally with disturbed or suicide-prone inmates.

Not every correction officer is capable of handling the delicate needs of suicide-prone inmates. Yet, the present practice seems to be to assign correction officers randomly to floor areas, with no regard for the individual correction officer's ability, and with no special effort to train the correction officer to recognize and deal with mentally disturbed inmates or emergency situations. Furthermore, there is often no effort made to inform the correction officer about the particular condition of each inmate in the area to which he is assigned. In short, there is no concern for any stable, systematic observation of such inmates. The overtime situation imposed on correction officers' schedules adds to the inadequacies of the present procedure. An overworked and untrained correction officer can hardly be expected to

respond adequately to the pressing needs of a mentally disturbed or distraught inmate.

Correction officer training should be patterned after that given to medical aides at Bellevue. The Department of Correction should work with HSA to develop a training program; correction officers selected for suicide-watch assignments should, if feasible, spend a period of time at Bellevue to learn the techniques employed there. Selected correctional aides should also undergo this training, and be assigned to areas where suicide-prone inmates are housed.

The Board urgently presents these recommendations for official action. They are the results of our discussions with heads of institutions, Department of Correction personnel, City medical officials, our hearings of August 31 and September 1, and our own intensive investigations into individual suicide cases. We submit these recommendations to Commissioner Benjamin Malcolm and Health Services Administrator Gordon Chase, appreciative of their dedicated and resourceful accomplishments in this critical area and confident that their own profound personal concern will move these recommendations to action.

The Board will report before October 1, 1972, regarding the progress of these recommendations.